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**REPORT OF THE TASK FORCE  
ON CHILD ABUSE/NEGLECT SYSTEM SAFEGUARDS**

**January 1992**

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### APPENDIX A: TASK FORCE ON CHILD ABUSE/NEGLECT SYSTEM SAFEGUARDS



## INTRODUCTION

Gary Stangler, Director of the Department of Social Services, appointed this Task Force on June 19, 1991 to review the statutes, policies and practices governing the reporting and the investigative, administrative and judicial responses to child abuse and neglect. Missouri's current system, which was a model for the nation when enacted in 1975, has been in effect for sixteen years. Although some legislative modifications have been made, the Task Force strongly agrees with Director Stangler that the time is at hand to thoroughly examine the system, to validate those elements which are working and to make changes in any areas which may need to be revised.

The full Task Force (see roster, Appendix A) has met five times. Information was presented to the Task Force by a number of individuals, each with a unique perspective on how the current child abuse and neglect (CA/N) system functions. The full Task Force also spent considerable time in dialogue on possible recommendations. Three subcommittees, Hotline, Investigations and System Integrity, examined different components in greater depth than was possible for the full Task Force. The Task Force approached its work with acute awareness that the investigation of child abuse is an emotional issue that affects families in a very personal way.

The Task Force prepared an interim status report in October that identified a wide range of issues to be addressed. It was determined at that time that certain recommendations would be finalized and presented to the legislative Interim Committee on System Safeguards for Child Abuse and Neglect, Director Stangler, and the people of Missouri, but it would be advisable to establish an ongoing advisory group to continue to work on some of the more complex issues. Therefore, this report contains administrative, legislative and judicial recommendations for short-term implementation, as well as a framework to guide further review of a comprehensive model which may require changes to be made

across service delivery systems including law enforcement, child welfare and the judiciary.

Based on the extensive experience of Task Force members and on information reviewed in the course of the Task Force's work, it is clear that Missouri has a fundamentally sound system for responding to reports of child abuse and neglect. The Division of Family Services has dedicated and competent staff doing a very difficult job. We believe that our recommendations can, upon implementation, make a sound system even better.

Missouri, like all other states, has seen a dramatic increase in the number of child abuse and neglect reports over the last ten years. This increase means that the child welfare system is interacting with a growing number of Missouri's families. For example, in 1980, reports were received of alleged abuse and/or neglect involving 60,274 children. By 1990, that number had risen to 73,399. With the increase in families who come in contact with the child welfare system, there has also been an increase in complaints that the child welfare system is unnecessarily interfering in parental decision-making. Conversely, many child welfare professionals and child advocates continue to believe that children and families needing help are being screened out by the system.

Families in Missouri are faced with major stresses and pressures both from within and outside the family system. These stresses include unemployment and underemployment, drug and alcohol misuse, limited access to preventive health care, needed medical care, unplanned pregnancies, discrimination, poor housing and lack of community resources to effectively assist the family. In many parts of the state, the Division of Family Services is expected to help families deal with these stresses. The Division of Family Services, while being a vital part of Missouri's support for its family, cannot be expected to be "all things to all people." It is important that the other state and local agencies, both public and private, be an integral part of the child welfare system.

The members of the Task Force commend Director Stangler and the legislative Interim Committee for initiating a thorough review of the safeguards in the system for handling reports of possible abuse and neglect involving Missouri's children. Keeping children safe from abuse and neglect is one of the most vital functions of our state's government. The rights of citizens who are accused of child abuse must also receive proper protections. The Task Force recommends that the system through which the state responds to indications of possible abuse or neglect be reviewed periodically to assure that the state is discharging effectively its crucial responsibilities. The members of the Task Force are honored to have a part in conducting the review now underway.



## **PHASE I: TASK FORCE RECOMMENDATIONS**

### **I. CHILD ABUSE AND NEGLECT HOTLINE**

The hotline provides a critical lifeline to children in need of protection and families in need of services. The hotline is a toll-free number (1-800-392-3738) which is manned by professional staff 24 hours a day, seven days a week. Approximately 45,000 reports of alleged abuse or neglect come in through the hotline each year. These calls are referred to county Division of Family Services (DFS) offices for investigation. An additional 45,000 calls are received which do not meet the statutory definition of child abuse or neglect. Many of the calls in the second category are requests for information or assistance with family problems not connected to abuse or neglect. Many of these calls are handled through the Parental Stress Helpline where hotline staff provide telephone counseling or refer the caller to a community resource in their area. Some calls are received alleging that a child has been assaulted, but not by someone having care, custody and control. These calls are referred to law enforcement or the juvenile office, depending on the age of the alleged offender.

All reports of abuse or neglect are reviewed to determine if the situation is an emergency needing an immediate response. County staff are notified if immediate face-to-face contact with the child is indicated. All reports are transmitted electronically via the computer system to the county office for investigation. Information received by the county office includes identifying information about the child, parents, alleged perpetrators and the reporter. Also, a summary of the allegations as stated by the reporter is sent.

The concerns of the vast majority of the reporters are genuine and their calls are made in good faith. However, a small percentage (estimated at less than one percent in 1990, and less than two percent in a study conducted in 1986) are made for the purpose of harassment. Since 1987, calls made to the hotline have been tape-recorded. Therefore, telephone calls can be reviewed if questions arise regarding possible harassment.

**Finding #1:** Hotline staff represent the front-line access point for people who believe that a child may be in need of help. It is critical that their skills and abilities are fully developed and that calls are handled in a consistent manner. Hotline staff must be able to assist the reporter in providing the information necessary to determine if a child abuse/neglect report can be taken. If a report falls outside the purview of the Division of Family Services, the reporter needs to understand why, what options may be available to secure assistance, and that, when appropriate, the hotline staff will make a referral to law enforcement or the juvenile office.

Most current hotline staff have field experience in investigations or other child welfare backgrounds. Hotline staff receive basic orientation and policy and procedure training.

**Recommendation:** Pre-service and in-service training requirements for hotline staff should be based on a more comprehensive curriculum, specific to their job duties, to assist staff to maximize their listening, questioning, note-taking and summarization skills. Such training will enable the hotline staff to perform more effectively their key role in ensuring that the safety-net works. We further recommend that periodic supervisory reviews of hotline tapes be conducted to monitor consistency and to help identify areas in which additional training would be helpful.

**Finding #2:** While the Task Force recognizes that the primary purpose of the hotline is to receive and disseminate reports of abuse or neglect, there are a large number of calls for help which do not meet the statutory definition of abuse and neglect. Many of these calls are handled through the Parental Stress Helpline and by referring the caller to a local resource. There has not been particular emphasis on the handling of these calls in either the staff training or in the procedures established for the hotline. Moreover, it is clear that some callers will not follow up by calling the local resource.

**Recommendation:** Training should be provided for hotline staff on how to assist a caller in contacting appropriate resources when abuse or neglect is not an issue. If staff do not believe the caller will follow through and they are in desperate need of assistance, they should obtain the caller's name and address and refer it to a local resource for follow-up. This part of the training should be designed to equip hotline staff to serve as an effective information and referral center for Missouri citizens in need of diverse services. The Task Force does not recommend that this role of the hotline staff be advertised unless additional staff resources can be provided; rather our intent is to make the staff more helpful in dealing with the nearly fifty percent of its calls that do not involve abuse or neglect.

**Finding #3:** In testimony presented to the Task Force and the legislative Interim Committee, some speakers recommended that anonymous reports should not be accepted by the hotline. It is their belief that many of these calls are made for the purpose of harassment. Hotline staff are able to obtain the reporter's name on eighty percent of the calls taken. In 1990, only 9,381 out of 45,143 calls were taken from anonymous reporters. As a result of these calls, over 1,200 children were identified as having been abused or neglected. The consensus of the Task Force was that anonymous reports should continue to be accepted.

### **Recommendations:**

- o The child abuse and neglect hotline staff should continue to strongly encourage the reporter to provide his/her name.**
- o If the reporter will not give his/her name, hotline staff should conduct a thorough telephone interview with the reporter to gather all relevant information as to the incident, with special emphasis on potential witnesses.**
- o If hotline staff suspect that a person is calling for the purpose of harassing an individual, they should explain the criminal penalties, and upon referral to the county, notify them that the possibility of harassment exists.**

**NOTE: Recommendations to help facilitate the appropriate use of the hotline by permissive and mandated reporters are contained in Section VII, "Public Awareness and Education."**

**Additional recommendations as to the handling of harassment calls are contained in Section IV, "System Integrity and Due Process."**

## **II. CENTRAL REGISTRY OF CHILD ABUSE AND NEGLECT**

**The primary purpose of the Central Registry is to record the names of individuals on whom a finding has been made that there is reasonable cause to suspect that they have abused or neglected a child. The records allow employers of persons who do or will provide services or care to children to make an inquiry on a prospective employee/volunteer to determine if there is a record of abuse or neglect. All such inquiries must be made in writing. Other persons as defined in Section 210.150, RSMo., can access this information, including law enforcement and DFS to identify patterns of abuse or neglect, and the Child Fatality**

**Review panels.** Information is only released after an investigation has been completed and a determination made.

Reports that are "unsubstantiated" are kept for five years (unless the person named receives a court order allowing expungement after one year), but are only accessible to law enforcement and the Child Fatality Review panels. The issues of adequate response time to inquiries from employers and names registered under an obsolete finding are addressed in this section.

**Finding #1:** Prior to November 1987, the Central Registry included individuals for whom there was no conclusive evidence of actual child abuse or neglect, but there were findings of "reason to suspect at risk." Typically, these cases involved family dysfunctions which, if unresolved, could result in abuse or neglect. A policy change by DFS in 1987 eliminated that particular finding, but those names entered in the Central Registry before that date under that finding remained on record. The finding used today in this type of case is "unsubstantiated - preventive services indicated," and the names of individuals on whom this finding is made are not included in the Central Registry.

**Recommendation:** Names of individuals who, prior to November 1987, were determined "reason to suspect at risk" should no longer be released to prospective employers. The data system which generates the information supplied to employers should be revised to assure these names are not inadvertently released.

**Finding #2:** The Division of Family Services has the responsibility of providing prospective employers with background information about individuals on whom a finding of "reason to suspect" abuse or neglect has been made. Concerns have been raised regarding the response time for notification to be returned to the employer. In 1988, a total of 11,506 requests for back-

ground screenings were received. It is estimated that over 31,000 will be received in 1991. Staff resources for this function have not increased with the additional requests. In addition, most of the work requires manual tracking of information. No fees are now charged for these record checks of prospective employees, although the Highway Patrol charges fees for criminal record checks.

**Recommendations:**

- o The Division should move immediately to automate the processing of inquiries from employers, with the goal of sending the results of all non-match (meaning no CA/N "reason to suspect" finding was found on this individual) name searches to the prospective employer within two weeks of receipt. Matches or potential matches should be sent to the requestor within two working days after it is determined the match is correct.**
- o If this timeframe cannot be met after the recommended changes in automation are implemented, additional clerical support should be provided to the unit.**
- o The Division should collect a reasonable processing fee from the prospective employer.**
- o Since a check of criminal records is not conducted by the Division of Family Services, employers should be informed on the return letter that they should ask the prospective employee to obtain same.**

### **III. INVESTIGATION AND TREATMENT OF CHILD ABUSE AND NEGLECT**

The need for additional differentiation between the investigation and treatment functions of the Division of Family Services is a theme that was raised in each subcommittee. Currently, most ongoing treatment services are provided by a children's services worker other than the investigator. The Task Force, at its meetings and at the public hearings, heard from many individuals both within and outside the child welfare system about the impact that a child abuse and neglect investigation has on the family and child. While some witnesses maintained that the system is too intrusive, others felt it does not go far enough in protecting children. In general, the current policies and procedures in effect within DFS are well-balanced. The protection of children from abuse and neglect through the provision of treatment to the family must be, and is, emphasized. Any changes to the child welfare system must reflect a child-centered, family-focused approach.

**Finding #1:** There is virtually no dissent that the protection and safety of children is the number one priority of the child welfare system. There are many diverse ideas about how these priorities should be fulfilled. Support, preservation and restoration of families are also important goals of the system.

Currently, DFS has programs such as Family-centered Services, Family Preservation and Children's Treatment Services which are used to treat the family while the children remain in the home. When a child must be removed, the Division places the child in relative care, foster care or a residential facility.

Permanency planning is pursued so that the child may return home or be adopted. While all these programs are beneficial, there is a great deal of concern that the current system does not have sufficient flexibility or resources to ensure that DFS interventions are appropriately targeted and consistently delivered in a

**fashion that both protects children and improves family functioning.**

**Recommendation:** The Task Force has identified parameters within which it recommends an alternative model for the delivery of child welfare services be researched and developed. Specific recommendations on the goals, development and potential implementation strategies for the model are detailed in the Phase II section. This section also contains the Task Force's recommendation that a small advisory group be appointed to help promote continued progress on the issues discussed in this report and to conduct further study of certain issues on which the Task Force was unable to make concrete recommendations.

**Finding #2:** A significant percentage of the "reason to suspect" findings are related to sexual abuse. In 1990, 2,291 children were identified as being sexually abused. Task Force research and public testimony clearly indicated the need for a comprehensive plan to address this issue. Of particular concern is the number of reports of sexual abuse made during custody disputes. In some instances, false reports may be lodged as a tactic to gain custody, while in other cases, legitimate reports may be discounted simply because divorce proceedings are pending.

In a review of examinations conducted by a group of physicians with special training for performing sexual abuse exams, called the SAFE (Sexual Assault Findings Examination) Network, the most common age of the child was three years (14% of all exams). Over eighty percent of the examinations were conducted on children ten years of age or younger. Many people question the ability of young children to know the difference between fact and fiction. There is also a belief that young children can be easily led to make accusations when, in fact, nothing occurred.

The legislature passed House Bill 1370 in 1990, which mandated that the Department of Social Services (DSS) develop protocols

for the investigation of child sexual abuse. It also authorized the establishment of a special team within DSS to provide training and assistance to county multidisciplinary teams in the investigation and prosecution of child sexual abuse cases.

The protocols developed by DFS have been shared with this Task Force. Unfortunately, the funds necessary to establish the sexual abuse team have not been available.

A Juvenile Sexual Offenders Treatment Network has recently been established to address the critical need for treatment services for juvenile sex offenders. Preliminary findings from this network indicate that many youthful offenders are not being identified or provided treatment.

**Recommendations:**

- o The Division of Family Services should take the lead in establishing a working group to bring together state and local agencies and professionals involved in the investigation, treatment and prosecution of child sexual abuse cases. Specific goals and timeframes should be established for the development, dissemination and implementation of protocols to address the identification and treatment of child sexual abuse victims and juvenile sex offenders. This working group should involve the community in any protocols and multidisciplinary teams that are developed. These protocols should complement the investigative protocol already developed by DFS.**
- o Funds should be appropriated to establish the special investigative team, as authorized by House Bill 1370.**
- o Specialized training should be developed and provided to DFS staff, law enforcement and prosecutors in the investigation and prosecution of child sexual abuse.**

- o Data should be compiled which will determine the prosecution and conviction rate of child sexual abuse cases and the average sentence. Once compiled, this information will be reviewed by the proposed Phase II advisory group to determine if further recommendations should be developed.**

**Finding #3:** In 1991, House Bill 185 was passed, mandating the creation of child fatality review panels in each county of the state. Effective August 28, 1991, these teams were required to review all suspicious child deaths. Many, but not all, of these teams have been established. Generally, the implementation of this legislation has gone well and has generated much support and cooperation. Since this is a new initiative, there is a potential for problems during the initial months.

**Recommendation:** Since it is vital that these panels function effectively, DSS and DFS must continue to provide the support necessary to get all teams implemented. In order to accomplish this, technical support should also be provided by the Missouri Office of Prosecution Services, Missouri Coroners' and Medical Examiners' Association, Missouri Juvenile Justice Association, Department of Health and other appropriate agencies and organizations.

**Finding #4:** The System Integrity subcommittee spent considerable time discussing the difficulties of conducting child abuse and neglect investigations in residential facilities. The Task Force also reviewed the recommendations of the "Out-of-Home Investigation Task Force" established by DFS. This report discussed the problems with inconsistent findings in the investigation of abuse/neglect in out-of-home facilities. There was particular concern by the subcommittee that staff who place children in a facility may also be called upon to investigate a report of abuse or neglect made on that same facility.

**Recommendations:**

- o DFS should develop one or more teams of specially-trained staff to investigate reports of abuse and neglect in out-of-home facilities. When possible, a multidisciplinary investigative team should be utilized, especially where more than one public agency has placed children in the facility.**
- o DFS should include specific guidelines on conducting investigations in out-of-home facilities in its policies and procedures manual.**

**Finding #5:** The Task Force spent considerable time discussing confidentiality issues. Of particular concern was the fact that DFS policy allows the alleged perpetrator total access to all information in the case record except for identifying information on the reporter, juvenile court information and law enforcement material.

**Recommendation:** The Phase II advisory group should examine further the possibility of restricting access to reports of abuse and neglect investigations and the option of removing witness names prior to release of the record.

**Finding #6:** The Task Force is convinced that there is need for an increase in the amount of specialized training provided to both DFS staff and law enforcement officers who are involved in child abuse/neglect investigations.

**Recommendation:** DFS staff and law enforcement officers who will be involved in the investigation of abuse and neglect should receive comprehensive specialized training. This training should be tailored to the individual needs of the investigators and have a multidisciplinary focus.

#### **IV. SYSTEM INTEGRITY AND DUE PROCESS**

The current process for an individual named as having abused or neglected a child enables him/her to request an administrative review or to file a judicial appeal, or to do both. The administrative review involves an initial review at the county level. If the decision is upheld by the county, a further review can be requested from the Child Abuse and Neglect Review Board (CANRB). The CANRB consists of seven to nine professionals from the community with expertise in child abuse and neglect. The final decision to uphold or reverse the investigation's finding is made by the department director.

The judicial appeal is conducted by the circuit court in the county where the individual resides. If the judge upholds the division's finding, the individual can request a review by a second judge in the same circuit, but no appeal beyond the circuit court is allowed.

**Finding #1:** A person named as a perpetrator currently must, in most cases, request a judicial review under Section 210.152 within 30 days of the notice of the finding. This does not allow sufficient time for completion of an administrative review before a request for a judicial review must be initiated. The administrative review and the judicial review, both requested within the same timeframe, employ different processes.

**Recommendations:** In order to make the appeal process sequential and more consistent with other due process procedures, the Task Force recommends the following:

- o That the Division provide each person named as a perpetrator with a clear explanation of his/her rights for appeal.

- o That Section 210.152 be revised to require the conclusion of an administrative review prior to filing a request for a judicial review.
- o That the proceedings of the CANRB be more formalized to allow for appeal at the judicial level to be completed based on that record. Guidelines for CANRB records should be developed.
- o That the de novo review at the circuit court level be eliminated and appeal be allowed beyond the circuit level.

**Finding #2:** The Task Force is concerned that under present mandated procedures, persons who report allegations of child abuse/neglect are not routinely informed of the conclusions reached in investigations, unless specifically requested, nor are they told how they may raise concerns regarding the outcomes of investigations. Further, these persons receive no notices regarding administrative appeals initiated by alleged perpetrators, and thus have no opportunity to provide input at either the first (county director) or second (CA/N Review Board) levels.

**Recommendation:** The Phase II advisory group should further review the option of requiring notices to reporters, informing them of the results of investigations and of the procedure they may use if they wish to raise concerns. The Phase II group should also consider the desirability and feasibility of reporters participating in administrative appeals.

**Finding #3:** The Task Force spent considerable time discussing the rights of the victim and reporter when a decision of the division is appealed. The Task Force also considered whether the victim or reporter should be allowed to request an administrative review of a finding of "unsubstantiated." Some thought that the review conducted by the CA/N review board was the appropriate time to raise these concerns.

**Recommendation:** No consensus could be reached on this issue and it was decided to leave this issue for further study (see "Victim and Reporter Rights" in Phase II).

**Finding #4:** The Task Force is aware that some calls are not made in good faith, but solely for the purpose of harassing or impugning the alleged perpetrator. Although studies indicate harassment calls constitute only a small fraction of the total number of calls received, the consequences of those reports are so egregious that this violation of the system must be addressed. The potential for misuse of the hotline will increase as the number of domestic cases embroiled in the legal system increases unless strong measures are taken to prevent that from happening.

**Recommendations:**

- o A specific set of case profiles, investigative protocols and referral criteria should be established and applied by DFS to identify harassment calls, gather and preserve evidence and make referrals for possible prosecution. These are currently being developed by DFS with prosecutors' input.**
- o DFS staff should refer all identified and documented harassment calls to the appropriate prosecutor.**
- o The prosecutor should review all referrals and take action on those that appear to be malicious in nature.**
- o The Division of Legal Services (DLS) within the Department of Social Services should assist the prosecutor in preparing his/her case.**

- o A central record within DFS or DLS should be maintained to track the referral of harassment calls to prosecutors and actions taken as a result of the referrals.

## **V. CHILDREN AND FAMILIES AND THE LEGAL SYSTEM**

When serious abuse or neglect occurs, it may result in referral to a court for intervention. The juvenile court may order the family to receive services or may remove the child from the family. A criminal court may become involved if there is evidence of a crime. Finally, if there is a custody issue, a third judge may need to make a decision on what is in the best interest of the child. There has been, in recent years, legislation offered which would create a family court to handle all issues involving children.

Finding #1: The Task Force heard from several individuals who experienced frustration and concern regarding the current legal system and how it handles child abuse and neglect situations. One person related in a public hearing that her daughter was required to provide information on what had happened to her more than 15 times in investigative interviews and court proceedings. That matter required testimony in three different courts (juvenile, criminal and a court hearing regarding custody).

Finding #2: In many areas of the state, there is minimal representation of children by the guardians ad litem (GAL). The guardian ad litem is normally an attorney in private practice appointed by the judge to represent the interests of the child. Section 210.160 requires training of guardians ad litem. This training requirement is not yet being enforced in all circuits. Also, GALs receive little ongoing information on the child from other professionals within the child welfare system on which to make their judgement as to what is in the best interest of the child.

**Finding #3:** Criminal and custodial cases can be long, drawn-out processes. This results in additional trauma to the child. A child may be prepared to testify, only to be told the hearing has been continued.

**Finding #4:** A state statute, the "Child Victim Witness Protection Law," allows for the video-recording of the alleged child victim. However, few courts use video during criminal trials, and recent federal court decisions have raised serious doubts about the constitutionality of such evidence.

**Finding #5:** There is continuing debate on whether young children ages three to six years are competent to testify even though Section 491.060, RSMo., provides exceptions for children under age ten.

**Recommendations:**

- o** Due to the number of courts that may become involved in a case of child abuse and neglect, legislation should be enacted to create a family court system in Missouri.
- o** Juvenile, criminal and custodial courts should coordinate their hearings involving children to prevent a child from having to testify several times before different courts. Priority should be given to child abuse cases on court dockets.
- o** Courts should comply with Section 210.160 and assure that training is obtained by all persons appointed to perform guardian ad litem duties in the area of child abuse and preparing of children for testimony. The curriculum currently used to train court-appointed special advocates (CASAs) should be considered as a training resource for GALs.

- o A special multidisciplinary group including professionals from child welfare, judicial and legal entities should be convened by DSS to thoroughly review statutory policies and judicial practices relating to the handling of trials involving children. This group should also determine if training for judges, juvenile courts, DFS, etc., should be developed. The findings of this group should be presented to the Supreme Court Task Force on Permanency Planning for their review, as well as to the Phase II advisory group.**

## **VI. CULTURAL SENSITIVITY**

**The Division of Family Services works with a diversity of ethnic and cultural groups. In order to provide better quality services, staff must understand the ethnic and cultural differences that affect family systems.**

**Finding: There has been little training of child welfare professionals on the dynamics of working with people of color and ethnic minorities. Many of these professionals come from backgrounds which are significantly different than the families they serve.**

### **Recommendations:**

- o The Department of Social Services and the juvenile court system should review policies, procedures and training practices to identify deficiencies in cultural and ethnic sensitivity and jointly develop a training strategy and implementation plans that will ensure that staff are sufficiently sensitive to cultural diversities. The training should include an understanding of cultural diversity and socioeconomic differences. The training should help assure that professional child welfare staff can relate to the families they work with in a non-judgmental way.**

- o The Department of Social Services should review its recruitment practices to assure that new staff are culturally sensitive.

## **VII. PUBLIC AWARENESS AND EDUCATION**

Effective parenting and an alert citizenry are the two most critical elements in protecting Missouri's children against abuse and neglect. Missouri has not, since the mid 1970's, undertaken a major public education effort related to child abuse and neglect, though the community plays a vital role in assisting families.

Finding #1: Many misconceptions exist as to what should be reported to the hotline as child abuse and neglect and myths abound as to how the Division handles the reports that it accepts. Many reporters are not aware of the statutory limitations on the Division relating to the investigation of child abuse and neglect. For example, DFS can only investigate reports where the alleged perpetrator has care, custody and control of the child. This lack of accurate understanding has resulted in frustration for those whose expectations of DFS have exceeded what DFS is statutorily authorized to do. Many of the myths about who makes hotline reports and what happens after a report is made, generate criticism of the system that is not factually based.

Recommendation: The Task Force recommends that a carefully designed public education campaign involving the Department of Social Services, the Missouri Chapter of the National Committee for the Prevention of Child Abuse, the Children's Trust Fund and other interested parties be implemented which:

- o Encourages and assists families to fulfill their responsibility to nurture and protect their children.

- o Highlights for all citizens their responsibility to help assure that Missouri's children have the opportunity to grow up safe and healthy, and emphasizes the vital importance of rekindling community concern and support for the protection and well-being of all children.
- o Encourages local community resources to provide opportunities for positive parenting and education.
- o Informs the public of how the child abuse/neglect reporting and investigation system functions, and of the importance of citizens reporting to state and local authorities, instances in which they believe children are being injured or endangered by abuse or neglect.
- o Specifies safeguards that exist in the system to protect the child while acknowledging parental rights.
- o Makes a special effort to target medical personnel, teachers, law enforcement and other mandated reporters of suspected child abuse or neglect, to emphasize the importance of their reporting obligations and to clarify the process.
- o Emphasizes the legal ramifications of making a malicious hotline report or using the hotline for the purpose of harassing an individual.

**Finding #2:** In order to prepare our children for adolescence and parenthood, it is critical that we provide appropriate education at an early age. It has been shown that abuse and neglect is often a learned behavior.

Children and adolescents spend a significant amount of their waking hours at school. It is in this setting that they can learn crucial "life skills," such as communication skills, self-esteem development, coping skills, peer referral techniques and

**conflict resolution. When this instruction is provided within a comprehensive health education curriculum and coordinated with the parent(s) of the child, it is an effective tool to increase future health and parenting relationship skills.**

**Recommendations:**

- o The Department of Elementary and Secondary Education (DESE) should provide comprehensive health education, including family life education, to children in schools.**
- o The Department of Social Services should work closely with DESE and the Department of Health in developing guidelines for local DSS staff, county health departments and Parents as Teachers, and other child- and family-oriented services staff on how they can and should work together in preventing child abuse and neglect, and promoting improved family functioning.**
- o DSS should intensify its cooperation with other service agencies with the objective of enhancing support and health education for families as a primary prevention of child abuse and neglect.**

## **VIII. DOMESTIC VIOLENCE AND CHILD ABUSE AND NEGLECT**

**The Task Force, in its meetings and at the public hearings, heard very dramatic stories of violence in the family. In many families where the child is abused or neglected, there is also violence against one caretaker by another. This can result in a continuing atmosphere of physical and emotional fear.**

**Child welfare professionals, including employees within the Department of Social Services, often do not receive training on the dynamics of domestic violence.**

**Finding #1: In 40 to 60 percent of the homes in which a child is abused, the mother is also battered.**

**Finding #2: Currently, there is little formal coordination between child welfare agencies and agencies providing services to battered spouses.**

**Finding #3: The battered woman is often blamed for not protecting the child, but not seen also as an abuse victim.**

**Recommendations:**

- o Those state agencies receiving funds for domestic violence programs such as the Division of Family Services, the Department of Mental Health and the Department of Public Safety, should work with domestic violence agencies to ensure that funds are spent on the most critical services, such as crisis intervention, parenting education, problem-solving and programs for children and youth of families subjected to domestic violence.**
- o The Department of Social Services should develop and provide training to all child welfare staff on the dynamics of domestic violence and options available to protect the children while helping the battered spouse. Other professionals who are involved in the investigation, prosecution and treatment of domestic violence should be included in this training.**
- o The Division of Family Services offices in counties having a domestic violence shelter should coordinate their services with those of the shelter.**

- o The court system should work with other child welfare professionals to remove the abuser, rather than the children, whenever possible.

## **IX. ACCOUNTABILITY WITHIN THE DIVISION OF FAMILY SERVICES**

The investigation of alleged child abuse and neglect is one of the most important and sensitive functions for which state government is responsible. It is vital that the process include safeguards which protect the lives and well-being of children, while at the same time, being protective of the rights of citizens who are accused of child abuse/neglect, those who report evidence of suspected abuse/neglect, and the families of the children who are the focus of such allegations.

The State of Missouri needs to take additional steps to provide assurance that appropriate policies and procedures exist and are applied properly and consistently in this critically important field.

**Finding #1:** Except for cases appealed, there is now no formal "post-audit" of findings resulting from child abuse/neglect investigations. Generally, only the social worker and his/her immediate supervisor review the findings.

**Finding #2:** Supervisors of child abuse and neglect staff need additional guidance on the monitoring, training and performance evaluations of their staff, and on the supervisors' roles in reviewing child abuse and neglect findings.

### **Recommendations:**

- o The Task Force is convinced that the importance of child abuse and neglect investigations is so great that a system-

**atic statewide review of a randomly selected sample of cases is essential. These reviews should be conducted by a small, highly expert team, working within a carefully developed protocol. Experience of other states with quality assurance processes should be reviewed so that Missouri's procedures can benefit from the lessons learned by others. A potential model of review is contained in "Division of Family Services Oversight" in Phase II for further study.**

- o DFS should enhance its guidance to supervisors of staff investigating child abuse and neglect cases, and should strengthen its "supervision of supervisors" in this critical functional area.**



## **PHASE II: RECOMMENDATIONS FOR FURTHER STUDY**

### **I. CHILD WELFARE SERVICE DELIVERY SYSTEM**

A considerable amount of time was spent by the Task Force discussing how to construct a model for child welfare service delivery that would provide children the protection they must have, and at the same time, provide more effective support to families in correcting the conditions and family dynamics that pose safety and health risks to children in their homes. The parameters and goals of such a model were constructed by the Investigations subcommittee. The Task Force set a timeframe for final recommendations to coincide with the deliberations of the legislative Interim Committee and that deadline did not permit the model to be fully researched and developed. Although it would be premature to recommend immediate statewide implementation of a model not yet completed, the Task Force recommends the following steps.

- o That DSS appoint a small, continuing advisory group to complete work on the model by building on key concepts and components devised by the Investigations subcommittee.
- o Once fully developed, the model should be introduced first in a limited number of diverse jurisdictions.
- o The advisory group should continue to work with DFS to monitor and evaluate the service delivery outcomes.

There was a strong feeling within the Task Force that DFS should be perceived in the community as a major source (but certainly not the only source) of family support services while also continuing to maintain a specialized investigative component. In some communities where the number of reported incidents of abuse are low, this is, in fact, how DFS is viewed. The Investiga-

tions subcommittee explored ways to achieve this on a larger scale throughout the state.

**Finding #1:** As CA/N reports steadily rise, less than adequate resources get stretched even thinner. This tends to drive the system to focus on its top priority, child protection, but leaves inadequate time, staff and resources for identifying and building on family strengths and helping increase the level of family functioning.

**Finding #2:** Joint investigations of CA/N reports are currently employed by DFS and law enforcement in most counties. These joint investigations work well, combining the strengths of two systems to ensure a more consistent standard for investigative procedures and sensitivity to the stress on alleged victims and family members.

**Finding #3:** The Task Force received a lot of feedback about how DFS interventions often do not seem appropriate to the circumstances of the family or needs of the child. Many individuals felt too few safeguards are in place for the child, while others felt that investigations are sometimes heavy-handed and inappropriate.

The model proposed for further study, refinement and potential implementation attempts to respond to the above findings. By building in the following system components, it is the belief of the Task Force that interventions can be more appropriately tailored to the precise nature of each reported incident.

**Please note, however, that system enhancements and safeguards can only do so much. Without adequate staff and funds, system failures will become an increasingly serious threat.**

The need for additional differentiation between the investigation and treatment functions of DFS was a theme that was raised in each subcommittee. The Task Force supports procedural chang-

es designed to strengthen the Division's identity as a family support agency. These changes would help ensure that the emphasis of DFS intervention, while remaining child-centered, would have a stronger family focus.

The proposed model would include a county-based risk and family assessment component which would identify abuse/neglect that required intensive investigation, intensive treatment, and/or removal of children from their home, and possible criminal or juvenile court intervention. These cases would be directed to a "protective services" track. Cases where the main concern seemed to be family functioning would be directed to a "family support" track for a family assessment and appropriate services. All reports, except those in the following five categories, would go initially to the family support unit and would not normally result in a record in the Central Registry which could be accessed by potential employers.

#### **PROTECTIVE SERVICE CRITERION**

1. Protective custody is taken by law enforcement, juvenile office or medical personnel.
2. Allegation of sexual abuse.
3. Child fatality.
4. Allegations of severe physical abuse or neglect, where it appears that a law violation has occurred or the child faces potential out-of-home placement.
5. Other reports which, in the judgement of the assessment unit, require involvement of law enforcement in the investigation.

Reports which fell into one of these five categories would be referred to the protective service unit and would be jointly investigated by specially-trained DFS workers and law enforcement officers. The Division would assign a case manager to work with the family in each phase, including investigation and treatment. When a protective service investigation resulted in a finding of "reason to suspect" that the reported incident occurred, the incident would be recorded in the Central Registry and be accessible by child-caring employers as provided by Section 210.150, RSMo. If criminal activity had occurred, a referral to the prosecuting attorney would be made by law enforcement.

The family support unit would work with families in which situations detrimental to the child were primarily the result of family dysfunction and could be addressed without seriously compromising the safety of the child or the integrity of the family. The family support unit would provide services to these families and work closely with other community agencies to procure necessary services. If the family support staff discovered that injury or risk to the children are more serious, they could refer the case to protective services staff at any time.

If a family had been referred to the family support unit as a result of a reported incident, but refused services, they would be placed on probationary status. That means that their case would remain open for one year. If no subsequent reports were made within that year which were determined to be valid, that case would be closed and no further action taken. If subsequent incidents of alleged abuse or neglect were to occur, the county could then renew attempts to deliver services or refer the case to the protective services unit for investigation.

The goal of providing these options is to help ensure the safety of the child while providing the kind of services that maximize the potential for positive outcomes for that child and do it in the context of his/her family, when feasible and appropriate.

**This model was advanced to the point where questions were raised that require more time for thoughtful answers. Some of these questions are listed below and are hereby referred to the advisory group for further discussion.**

- o Should every case which meets one or more of the five protective service criteria be jointly investigated by DFS and law enforcement?**
- o How can the system ensure that needed services are mandated if families on the family support side are resistant to services?**
- o How can services best be coordinated between the protective services unit and the family support unit?**
- o What will the county-level assessment consist of?**
- o What safeguards are needed on the family support side to ensure adequate protection of the child?**

**The remainder of the report addresses five topics that also require further examination. The Task Force believes that the recommendations contained herein and the additional issues they have identified will lay a firm foundation for the advisory group as they work to advance their efforts and to make the best system possible a reality for the workers, the children and their families.**

## **II. REASON TO SUSPECT**

**Currently, a DFS investigation results in one of three findings: reason to suspect, unsubstantiated - preventive services indicated, or unsubstantiated. Terms other than "reason to suspect" have been suggested, such as "probable cause."**

Initially, probable cause raised few concerns with the majority of the Task Force members, including one attorney who researched this legal term further. This research revealed a flaw in some of the assumptions that were made as to how the term would be applied. There appears to be potential for misapplication of a legal term from the criminal law field if the term were used in regard to non-criminal child abuse/neglect proceedings. The Task Force concluded at that point, that the issue of choosing a mutually acceptable and appropriate legal term would require further study and discussion in order to avoid unintended consequences. Additional options, such as a finding of "reasonable probability," should be reviewed.

### **III. CONFIDENTIALITY AND ACCESS TO RECORDS**

The Task Force was divided on how and when to restrict access to DFS records kept as a result of child abuse and neglect reports. Section 210.150, RSMo. specifies who may have access to the record. Currently, the Division releases to the parents of the child and to the alleged perpetrator, all information except identifying information on the reporter, juvenile court information and preliminary law enforcement reports. Several Task Force members felt that DFS should be more restrictive in what it releases to the alleged perpetrator unless the decision is appealed to a court. Of particular concern is the names of witnesses to the abuse or neglect. Other members of the Task Force felt DFS should continue with its current policy.

Several other states were researched and it was determined that most states restrict access to some degree. Therefore, this issue should be reviewed in Phase II.

#### **IV. VICTIM AND REPORTER RIGHTS**

Currently, the administrative and judicial reviews are available to persons alleged to have abused or neglected a child where there has been a finding of "reason to suspect." These individuals can ask for administrative and/or judicial reviews. These reviews rarely involve representation for the victim other than DFS staff. In addition, there is no process for a victim or the reporter to formally ask for a review of a case that was unsubstantiated. The Task Force discussed this issue in detail. Cited as potential problems with allowing reporter appeals were confidentiality and legal standing. Several Task Force members felt that a thorough investigation of the incident by DFS was sufficient protection for the victim. The Task Force could not reach a consensus at this time and is recommending that this issue receive further study.

#### **V. DIVISION OF FAMILY SERVICES OVERSIGHT**

The Task Force heard from individuals who felt that there should be an independent body which could review child abuse and neglect investigations and the handling of same by DFS. Recommendations such as an "ombudsman" outside DFS were suggested at the public hearings. The Task Force believes that the creation of an independent body outside DFS needs further study. One Task Force member submitted the following model for study.

Establishment of a small, highly capable review staff within the Department of Social Services, but outside the Division of Family Services, can make a substantial contribution to both the actual and the perceived integrity of the child abuse/neglect investigation process.

Specifically, a new Office of System Accountability (OSA), reporting to the department director, could be created. While the

**mandate of OSA might be expanded later, it would be charged initially with the following functions:**

- o Review of randomly-selected samples of child abuse/neglect cases to determine whether policies and procedures were applied properly and to identify any issues relating to the performance of staff responsibilities.**
- o Review of complaints regarding the conduct of child abuse/neglect investigations, including allegations that specific reports were not adequately investigated or that erroneous conclusions were reached.**

**The Office of System Accountability should be headed by a senior attorney or child protection expert. Initial staffing should include at least two full-time review officers in addition to the office director.**

**In making its reviews of randomly-selected cases, OSA would function much like the quality control staffs for the AFDC, Medicaid and Food Stamp programs. It would periodically present statistical reports and summary histories of the cases it reviewed, along with assessments of the policy, procedural and resource implications of its findings to the department director.**

**In reviewing complaints submitted to the Department, OSA would not function as a formal appeals body and would not have authority to overrule the Division of Family Services. When OSA determined that mistakes had been made in the handling of particular cases, it would provide its preliminary findings to the Division of Family Services. The Division would have an opportunity to provide additional information or otherwise to challenge the tentative conclusions. OSA would thereafter reach its final judgement on the matter and advise the department director and the Division of Family Services accordingly. DFS would then be required to take any appropriate action relative to the case**

reviewed and take steps to preclude similar problems from occurring in the future.

A carefully-designed protocol would guide the work of OSA, including the sensitive issue of communications with complainants. The work of OSA would be largely invisible to those outside the Department, except that complainants would be informed that their concerns were being reviewed by OSA and would be notified, in general terms, of the outcome of the reviews.

## **VI. STAFFING OF CHILD WELFARE SERVICES WITHIN THE DIVISION OF FAMILY SERVICES**

DFS does not have a sufficient number of personnel, both direct services staff and supervisors, to provide the service it is statutorily mandated to provide. Based on national caseload standards, DFS is at approximately 78% of the minimum staffing level recommended. Because of the budget situation in Missouri, DFS has also found it necessary from time to time to freeze the hiring of staff to replace those who have left. This has resulted in low morale and overworked staff. The Task Force believes that the current staffing level should be studied in detail to determine what steps should be taken to assure DFS has sufficiently trained and experienced staff to assure it can provide quality services to children in need of protection.



## **SUMMARY**

**The Task Force believes that the recommendations contained in this report will benefit the Department of Social Services in its quest to enhance the critically important child welfare system. Of equal importance are the issues that have been identified for a more in-depth analysis. Systemic integrity is too great a goal to be dealt with hastily in order to meet superficial timelines or self-serving agendas. This report concludes with the expectation and departmental affirmation that the work begun by this Task Force will continue. The State of Missouri will be well-served by an ongoing review process dedicated to finding honest and fair answers to difficult questions.**



**APPENDIX A**  
**TASK FORCE ON**  
**CHILD ABUSE/NEGLECT SYSTEM SAFEGUARDS**

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